E-mail notice sent to all Hospital Data Reporting Contacts on January 18, 2006

Subject: Arizona Hospital Discharge Data Update: Audit Errors

The purpose of this e-mail is to provide information regarding two significant errors that are routinely occurring in the data reported by many Arizona hospitals. Before we begin auditing for these errors and requiring corrections, we wanted to take this opportunity to notify all hospitals of these issues, so that any related concerns may be addressed in advance.

The first issue is in regard to Place of Occurrence E-codes. With the 2005-01 reporting period, we began auditing for this data element on all records with an E-code for cause of occurrence indicating the patient was injured in a fall. As hospitals have moved to ensure reporting of this data element, it has come to our attention that many hospitals appear to be using the E-code *E8499 – unspecified place* in a manner contrary to National Coding Guidelines in order to clear the errors on this audit.

Based on this guideline, the only time E8499 would be used is on those occasions where the place of occurrence is stated in the record, but the described place is not represented under any of the other, more specific codes available to indicate place of occurrence. The high volume of records coded with the E8499 code (at some hospitals exceeding 50%), indicates the probable use of this code on records where the place of occurrence is not stated.

We understand that you cannot code information that is not present in the record. However, if you are following Coding Guidelines and still have a significant number of records failing this audit, the question then becomes why is the place of occurrence not stated in the record, and how can this be corrected in the future? Steps must be taken to enable collection of this information.

The second issue is in regard to Cause of Occurrence E-codes. It has come to our attention that many hospitals are providing Cause of Occurrence E-codes on injury patients that have transferred in from another hospital. This is contrary to National Coding Guidelines, and introduces inaccuracy into the state data in the form of redundant injury reporting. The National Coding Guidelines clearly state that E-codes are to be used for the initial encounter only. Therefore, on any record displaying a source of admission of *4-transfer from a Hospital*, an E-code on the principal diagnosis is neither accurate nor expected by the Department.

Auditing for these errors will commence with 2006-01 data. You are being notified of these issues at the beginning of the time period when the 2006-01 data is being created, so you may effectuate any necessary changes moving forward. It is the expectation of the Department that coding related to these data elements will show improvement during the

2006-01 period and will be in compliance with the reporting requirements effective with the 2006-02 period.

It is the intention of the Department to collect data that has been coded in compliance with National Coding Guidelines. If at any time you believe the Department is requiring you to do something contrary to those Guidelines, please notify our office immediately.

Please distribute this information to any hospital staff involved with or affected by the coding or state data reporting processes.

Thank you.